MERCYONE

Influenza Immunization Consent Form

Print Name: _____ Birthdate:_____
Last First M.I.

Patient Address: _____City: _____ State:_____ Zip: _____

Patient Phone Number: _____Age: _____

Medicare Number/Insured ID Number: _____

Insurance Carrier: _____ Relationship to Cardholder: _____

BIN #: _____ RX Group #: _____ PCN #: _____

Please answer the following questions. If you are unsure, the pharmacist will discuss the item with you.

☐ Yes	☐ No	Are you sick today? (fever greater than 101.3°F or 38.5°C)
☐ Yes	☐ No	Have you ever had Guillain-Barré syndrome?
☐ Yes	☐ No	Have you received the flu vaccine in the past?
☐ Yes	☐ No	Have you ever had an allergic or serious reaction to flu vaccine, chicken eggs, or chicken products?
☐ Yes	☐ No	Are you under the age of 18? **If yes, parental consent is required**

I have received and read the Vaccine Information Statement for the vaccines listed on the bottom of this handout and have had the opportunity to ask questions of a qualified health care provider. I understand the benefits and risks of vaccination and request to receive the vaccine.

Patient Signature: _____ Date: _____

Parent Signature if patient under 18 years of age: _____

Flu Immunizations are given in accordance with State of Iowa Standing Order for Administration of Flu Vaccine under prescriber Dr. Robert Kruse, MD.

Manufacturer/Lot/Exp	**Influenza** ☐ 0.5ml **Route-** Intramuscular Right Left	**VIS Publication Dates** Influenza (01/31/25)

Administered by:

Signature: _____Date: _____

VIS Provided by immunizer listed above. Entered in Iris:_____QS1_____ Date:_____

2025 Version